CONTACT REGISTRATION FORM

PLEASE PRINT CLEARLY AND COMPLETE CLIENT SECTION & SIGN BELOW

Referrals: _____

_____

Pregnant? Y N

Action Taken: _____

_____

_____

Health Dept. Use Only

Today's Date: _____ **Site:** _____

CLIENT SECTION

(Patient's Name) **PLEASE PRINT**

Last _____ First _____ Middle _____

Birth Date ____/____/____ SSN _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Phone(_____) _____ Mobile Phone: _____

Race _____ Sex _____ Marital status _____ Physician/Provider Name _____

Provider Phone _____

Emergency Contact _____ Phone _____

HEALTH DEPARTMENT USE ONLY

Contact Association

_____ _____

_____ _____

_____ Other _____

Prior Mantoux TST? Y N

If yes, Date: _____ Induration _____

Location where test was performed _____

Prior Treatment? Disease _____ LTBI _____

Meds Taken _____

_____

Location of Treatment _____

TST #1 – Arm: ____ Left ____ Right

Date Given _____ Time _____ Lot # _____

Date Read _____ Time _____

Induration _____ mm _____ Positive ____ Negative

Signature _____ Pos # _____

TST #2 – Arm: ____ Left ____ Right

Date Given _____ Time _____ Lot # _____

Date Read _____ Time _____

Induration _____ mm _____ Positive ____ Negative

Signature _____ Pos # _____

TB Symptoms (Check all that apply)

_____ None

_____ Cough > 3 weeks

_____ Productive? Y N Hemoptysis? Y N

_____ Fever, unexplained

_____ Unexplained weight loss

_____ Poor appetite

_____ Night Sweats

Fatigue _____

These symptoms should be evaluated in context

Additional Individual Risk for Infection
(Check all that apply)

_____ Lived-High Prevalence Country
List country _____

_____ Resident/employee congregate setting

_____ Medically underserved

_____ Uses illegal drugs

_____ Homeless within last 2 years

_____ Past known contact When/Where? _____

Individual Risk for Progression to Disease

_____ HIV infection

_____ Medical conditions that increase risk (diabetes, ESRD, Cancer, 10% below ideal weight, etc.)

_____ History of inadequate TB treatment

_____ Immunosuppressive therapy (steroids, cancer treatment, including treatment for Rheumatoid Arthritis such as Remicade, Humira, etc.)

- I hereby authorize the doctors, nurse, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) to me or my child named above.
- I agree that the results of this test may be shared with other health care providers.
- The Deemed Consent for blood borne diseases has been explained to me and I understand it.
- I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
- I understand that:
  - this information will be used by health care providers for care and for statistical purposes only.
  - this information will be kept confidential.
  - medical records must be kept for 5 years after death, 10 years after my last visit, or 4 years after the age 18 for any minor child.

X _____ Date _____